**LARA Use Only**

<table>
<thead>
<tr>
<th>Date</th>
<th>Program #</th>
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- [ ] Initial app.
- [ ] renewal app.
- [ ] changes (addendum)

**STATE OF MICHIGAN**

**NURSE AIDE TRAINING PROGRAM APPLICATION**

Michigan Department of Licensing and Regulatory Affairs (LARA)
Bureau of Community and Health Systems
Health Facility Licensing, Permits and Support Division
611 W. Ottawa Street, P. O. Box 30664
Lansing, MI 48909

1. **Applicant Information**

- Program/ Facility Name (NATP#)
- Program Address
- Classroom Address if Different from Program Address
- Laboratory Address if Different from Program Address
- (City) (State) (ZIP Code)
- Contact Person
- Contact Number and E-mail address

**Type of Program (please check the appropriate box):**

- [ ] Long Term Care Facility (Nursing Home/County Medical Care Facility/Hospital Long Term Care Unit)
- [ ] Proprietary Education
- [ ] Adult Basic/ Community Education
- [ ] Community College
- [ ] Vocational Education
- [ ] Other (Please specify)

2. **Program Coordinator**

- Full Name
- Trainer Certificate Number and Date Issued
  - 4704-
- Michigan RN License Number and Expiration date

3. **Primary Instructor**

- Full Name
- Trainer Certificate Number and Date Issued
  - 4704-
- Michigan RN License Number and Expiration date

4. **Delegated Instructor/Alternate Instructor (please indicate)**

- Full Name
- Trainer Certificate Number and Date Issued
  - 4704-
- Michigan RN License Number and Expiration Date
5. Changes to NATP:  [ ] add  [ ] delete  [ ] current

Facility/Program Name:

Contact Person

Street Address

(City)  (State)  (ZIP Code)

Contact Number  Fax number

6. Formal Collaborative Relationship—PLEASE ATTACH WITH THIS APPLICATION  [ ] add  [ ] delete  [ ] current

This is an agreement between two programs to coordinate or shard teaching responsibilities or sites or program and a long-term care facility to utilize facility for clinicals. This relationship requires a contract, which outlines the roles and responsibilities of each party involved and is signed by both parties.

Facility Name Entering Into Contract With

Contact Person

Street Address

(City)  (State)  (ZIP Code)

Contact Number  Fax number

7. Attestation

I certify that the following is true:

a) Our program follows the State of Michigan Nurse Aide Training Curriculum Model.

b) There is sufficient space available for training and is environmentally controlled.

c) Equipment and supplies are available to ensure that each student has the ability to meet course objectives.

d) The program is in compliance with Federal and State requirements.

e) The information included in this application is complete and true.

Applicant signature  Date

Application packet submitted by U.S. Mail:
Michigan Dept. of Licensing & Regulatory Affairs
Bureau of Community and Health Systems
Health Facility Licensing, Permits and Support Division
P. O. Box 30664
Lansing, MI 48909

Application packet may also be submitted by the following methods:
Fax: 517-241-3354

E-mail: BCHS-CNA-Training-Program@michigan.gov